TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
EDWARD ICAZA, MD

Respondent Name
SPRING ISD

MFDR Tracking Number
M4-18-0460-01

Carrier's Austin Representative
Box Number 43

MFDR Date Received
OCTOBER 23, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Requestor's Supplemental Position Summary: "There is still a balance of $136.63."

Amount in Dispute: $925.38

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the payment and EOB for MDR –M4-18-0460-01."

Response Submitted By: York

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 21, 2017	CPT Code 99204 New Patient Office Visit	$268.99	$0.00
	CPT Code 95886 (X2) Needle EMG	$299.76	$0.00
	CPT Code 95910 Nerve Conduction Studies	$324.73	$0.00
	HCPCS Code A4556 Electrodes	$16.90	$0.00
	HCPCS Code A4215 Needle	$15.00	$0.00
TOTAL		$925.38	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced / denied by the respondent with the following reason code:
   - 219-Based on extent of injury (Note: To be used for workers' compensation only).
   - PLN-11/Peer review on file for extent of injury.**Billing unrelated to Workers' compensation diagnosis.
   - P13-Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - P14-The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day.
   - W3-Additional payment made on appeal/reconsideration.
   - 193-Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
   - P5-Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement.

Issues

1. Does an extent of injury issue exist in this dispute?
2. What is the applicable fee guideline for professional services?
3. Was the office visit billed in accordance with fee guideline? Is the requestor entitled to reimbursement?
4. Is the requestor entitled to additional reimbursement for CPT codes 95886 and 95910?
5. Was HCPCS code A4556 billed in accordance with fee guideline? Is the requestor eligible for reimbursement per guidelines?
6. Was HCPCS code A4215 billed in accordance with fee guideline? Is the allowance of HCPCS code A4215 included in the allowance of another procedure performed on the disputed date of service? Is the requestor eligible for reimbursement per guidelines?

Findings

1. According to the explanation of benefits, the respondent initially denied reimbursement for the disputed services based upon "219-Based on extent of injury (Note: To be used for workers' compensation only). Upon reconsideration the respondent did not maintain the extent of injury denial and issued payment of $642.30 for the disputed services. The division finds that an extent of injury issue does not exist in this dispute.
2. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.
3. A review of the submitted explanation of benefits finds the respondent denied reimbursement for CPT code 99204 based upon "P13-Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies."

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   CPT code 99204 is described as "Office or other outpatient visit for the evaluation and management of a new

patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family."

On the disputed date of service, the requestor billed for CPT code 99204, 95910, 95886, A4556 and A4215. Per 28 Texas Administrative Code §134.203(a)(5), the Division referred to Medicare's coding and billing policies. Per Medicare fee schedule, CPT code 95886 has a global surgery period of "ZZZ" and code 95910 has "XXX.

The National Correct Coding Initiative Policy Manual, effective January 1, 2016, Chapter I, General Correct Coding Policies, section D, states:

> All procedures on the Medicare Physician Fee Schedule are assigned a Global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier (A/B MAC processing practitioner service claims). All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure… Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. Appending modifier 25 to a significant, separately identifiable E&M service when performed on the same date of service as an "XXX' procedure is correct coding.

The Division finds that the requestor did not identify a significant and separate E&M service to support billing CPT code 99204 in conjunction with CPT codes 95886 and 95910. In addition, the requestor did not append modifier 25 to CPT code 99204 per the correct coding guidelines. Therefore, the Division finds that the requestor's documentation did not support billing CPT code 99204. As a result, reimbursement is not recommended.

4. To determine if additional reimbursement is due for codes 95886 and 95910 the division refers to 28 Texas Administrative Code §134.203(c)(1)(2).

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

Place of Service is 11-Office Based.

The 2017 DWC conversion factor for this service is 57.5.

The Medicare Conversion Factor is 35.8887

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77042, which is located in Houston, Texas; therefore, the Medicare participating amount is based on locality "Houston, Texas".

Using the above formula, the division finds the following:

Code	Medicare Participating Amount	Maximum Allowable Reimbursement	Carrier Paid	Amount Due
95910	$196.67	$315.10	$324.73	$0.00
95886 (X2)	$93.26	$149.42 X 2 units = $298.84	$299.76	$0.00

5. HCPCS code A4556 is defined as "Electrodes (e.g., apnea monitor), per pair." Based upon the submitted documentation the requestor billed $16.90 and was paid $16.90. As a result, additional reimbursement is not recommended.

6. HCPCS code A4215 is defined as "Needle, sterile, any size, each." Based upon the submitted documentation the requestor billed $15.00 and was paid $0.91.

   Per Medicare guidelines, Transmittal B-03-020, effective February 28, 2003 if Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) HCPCS codes are incidental to the physician service, it is not separately payable. A review of the submitted documentation does not support a separate service to support billing HCPCS code A4215 in conjunction with CPT codes 95886 and 95910. As a result, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		12/13/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.